Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: SPECIALTY SURGERY CENTER DALLAS PO BOX 674018 DALLAS TX 75267	MFDR Tracking #: M4-08-5800-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: ZURICH AMERICAN INSURANCE CO Box #: 19	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Rationale for Increased Reimbursement: "Did not follow WC Guidelines."

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Medical Records
5. Total Amount Sought - $64.40

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "Carrier has paid or will pay all reasonable, necessary and related charged in accordance with the applicable fee guidelines."

Principal Documentation:

1. DWC 60 Package

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
1/28/2008	L8699 - Prosthetic implant, not otherwise specified	Not Applicable	$64.40	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. This request for medical fee dispute resolution was received by the Division on May 15, 2008.
2. Division rule at 28 TAC §133.307, titled *MDR of Fee Disputes*, effective December 31, 2006, 31 TexReg 10314, sets out the procedure for requesting medical fee dispute resolution.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 4/28/2008

   - F-Reimbursement has been calculated according to state fee schedule guidelines.

Issues

1. Was the dispute filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307?

Findings

1. Division rule at 28 TAC §133.307(c)(2)(A) requires that the request shall include "a copy of all medical bill(s)… as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration…" Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of all medical bill(s) as originally submitted to the carrier. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed under Division rule at 28 TAC §133.307(c)(2)(A).

   Division rule at 28 TAC §133.307(c)(2)(B), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include "a copy of each explanation of benefits (EOB)... relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB." Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of the EOB detailing the insurance carrier's response to the request for reconsideration. Nor has the requestor provided evidence of carrier receipt of the request for an EOB. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed under Division rule at 28 TAC §133.307(c)(2)(B).

   Division rule at 28 TAC §133.307(e)(3)(C) states that the Division may dismiss a request for dispute resolution if "the Division determines that the medical bills in the dispute have not been submitted to the carrier for reconsideration." The Division finds that the requestor did not submit any documentation to support that the disputed bill had been submitted to the respondent for reconsideration of payment prior to seeking medical dispute resolution in accordance with Division rule at 28 TAC §133.307(e)(3)(C).

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(A), §133.307(c)(2)(B), and §133.307(e)(3). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $0.00 reimbursement for the services involved in this dispute.

		8/10/2010
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.